Renewal Date:

Montana Department of Labor & Industry
Employment Relations Division, Workers' Compensation Regulation Bureau
P.O.Box 8011
Helena, Montana 59604
Phone: (406) 444-1555 Fax: (406) 444-7710 Email: dhorning@mt.gov
Website: Self-Insurance Plan 1

Date Stamp - Office Use Only

Workers' Compensation Self-Insurance Application for 2015

Complete this form in its entirety. Unanswered questions may delay processing.
Refer to the related instruction sheet on the above web site for details.

Check One: ☐ New ☐ Renewal ☐ New member of existing group

Group Name: _____

If new, proposed effective date of self-insurance coverage: _____

GENERAL INFORMATION

Name of Company: _____ Date Established: _____

Date Company Started Business in Montana _____

Address: _____ Federal Employer Tax ID #: _____

_____

Parent Company : _____ Date Established: _____

Address: _____

_____

Montana Operations (continue on separate sheet if necessary):

	Legal Name	Number of Employees	Location	Nature of Business
1				
2				
3				
4				

Total Number of Montana employees (Number of W-2's plus Volunteers) 0

Gross Montana Annual Payroll for CY 2014 $ -

Company Official(s) to Contact Regarding Self-Insurance:

	Name	Title	Address	E-Mail	Phone No.
1					
2					

Company Official(s) to Contact Regarding Montana Operations:

	Name	Title	Address	E-Mail	Phone No.
1					
2					
3					

ACCIDENT AND CLAIM SUMMARY

Claims reported on: ☐ Policy Year ☐ Fiscal Year ☐ Calendar Year

Claim Year: beginning date _____ ending date _____

ACCIDENTS BY YEAR:	**2014**	**2013**	**2012**	**2011**	**2010**
# Medical Only					
# of Lost Time					
# of Fatal					
TOTAL Accidents	0	0	0	0	0

ALL CLAIMS BY YEAR:	**<----- All Claims Open & Closed ----->**					**Open Claims Only for Years Prior to**
	2014	**2013**	**2012**	**2011**	**2010**	**2010**
Total payments made: (line 1)	$ -	$ -	$ -	$ -	$ -	$ -
Unpaid reserves, without IBNR, as of end of most recent year: (line 2)	$ -	$ -	$ -	$ -	$ -	$ -
Total incurred liability, without IBNR, updated as of most recent year-end: Sum of line 1 + line 2	$ -	$ -	$ -	$ -	$ -	$ -
Expected recoveries from excess insurance carrier	$ -	$ -	$ -	$ -	$ -	$ -

When were Reserves last updated? _____ By Whom? _____

Three Year Average Incurred Liability (Use 2013, 2012, 2011): $ -

Undiscounted Total Estimated UNPAID Liability On All Montana Claims:

For claims incurred before 7/1/89:

For claims incurred on or after 7/1/89:

Total Claims: $ - (sum of line 2 above) $ -

Total Cash Paid During the *Last Calendar Year* (1/1/2014 - 12/31/2014):

Indemnity	+ Medical	+ Other	= Total
			$ -

Medical payments in excess of $200,000 per claim during last calendar year _____

Are estimated unpaid compensation and medical liabilities included on company balance sheet?
☐ Yes ☐ No

If yes, how are they classified? _____
If no, explain. _____

Do you have a formal safety program? ☐ Yes ☐ No

Is there a Safety Engineer at Montana locations? ☐ Yes ☐ No

CLAIMS EXAMINER INFORMATION

Name of Montana Examiner _____ Phone _____
Address _____
E-Mail address _____
Location of Montana Claim Files _____
Third-Party-Administrator (if applicable) _____

SECURITY & EXCESS INSURANCE INFORMATION

Surety Bond:
Name of Surety Company _____ Phone _____
Address _____
Bond Amount $ - Effective Date _____

Letter of Credit:
Name of Bank _____ Phone _____
Address _____
LOC Amount $ - Effective Date _____

Government Bond/Security:
Type of Bond/Security _____ Cusip# _____
Interest 0.00% Maturity Date _____
Bond Amount $ - Effective Date _____

Certificate(s) of Deposit:
Name of Bank(s) _____
Certificate Number(s) _____ _____ _____
CD Amount(s) $ - $ - $ -

Specific Excess Insurance:
Name of Insurance Carrier _____
Effective Date _____ Expiration Date _____
Self-Insured Retention (SIR) $ - Policy Limit $ -
Deductible $ -

Aggregate Excess Insurance:
Name of Insurance Carrier _____
Effective Date _____ Expiration Date _____
Self-Insured Retention (SIR) $ - Policy Limit $ -

ELECTION AND CERTIFICATION

We hereby make application to be a self-insured employer in Montana and certify that all of the information provided is correct. Our firm is an employer in the State of Montana. If we are granted self-insured status by the Department, we agree to comply with and be bound by all of the applicable laws, rules, and regulations of Montana pertaining to workers' compensation and occupational disease.

We agree to notify the Department of Labor & Industry and the Montana Self-Insurers Guaranty Fund within 24 hours of the filing of any bankruptcy or determination of insolvency relating to this firm.

This election is made by the firm and authorized by the directors, officials, officers, by-laws, owner, or partners.

Typed Name	Title	Phone	Date

Authorized Signature

Typed Name	Title	Phone	Date

Authorized Signature

MONTANA WORKERS' COMPENSATION SELF-INSURANCE APPLICATION for 2015
Supplemental Page